San Diego County
CMS Program
Work History Information

The CMS Program has received a request from your doctor for a procedure or service that is limited by program policy. We need more information from you to determine if the requested service meets all of the CMS Program guidelines to be a covered service. Your cooperation is appreciated
ALL questions must be answered and the form returned by the date shown.

Date Sent: _____ **This form must be returned by**: _____

Your Name:_____ SSN:_____

Phone Number**:**_____ DOB**:**_____

1. What kind of medical service do you need? _____
2. What kind of work do you do when you are working? _____
3. Are you currently employed? [ ] Yes [ ] No
4. Are you currently Receiving State Disability? [ ] Yes [ ] No
5. Are you currently receiving workers compensation? [ ] Yes [ ] No
6. Date you last worked? _____

IF YOU ARE CURRENTLY UNEMPLOYED:

1. Why did you leave your last job?_____
2. Have you applied for or been offered employment in the past six (6) months? [ ] Yes [ ] No
3. Have you recently been turned down for a job because of this medical condition? [ ] Yes [ ] No

TELL US WHO YOUR CURRENT EMPLOYER IS OR ABOUT THE COMPANY WHO HAS OFFERED YOU EMPLOYMENT.

Name of company:_____

Person to contact:_____ Phone:_____

If you are currently employed you can speed up the review process if you would have your employer send a letter on business letterhead. This letter should tell us about your employment and how this condition affects your ability to do your job. Attach the letter to this work history and send them to:

CMS Program
ATTN: Patient Relations Coordinator
PO Box 939016
San Diego, CA 92193
(858) 492-4444/North County (760) 471-9660

I authorize the CMS Program to contact the persons/organizations named above to verify the information presented.

Patient Signature: _____ Date: _____